3 Long Term Care Facility Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided through the long term care facility program as deemed appropriate by DHW. It addresses the following:

- Claims payment
- Electronic claims billing
- Paper claims billing
- Covered services
- Leave of absence (LOA)
- Level of care revenue codes

Note: Long Term Care services are covered for **Enhanced Plan** participants.

3.1.2 Advance Directives

Long term care providers must explain to each participant his/her right to make decisions regarding his/her medical care, which includes the right to accept or refuse treatment. Long term care providers will inform the participant of his/her right to formulate advance directives, such as a living will or durable power of attorney for health care at the time of the participant's admission as a resident.

3.1.3 Customary Fees

Medicaid reimburses long term care services on a per diem rate basis. A separate rate is assigned to each facility.

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid Primary Care Case Management (PCCM) model of managed care. If a participant is enrolled, certain guidelines must be followed to ensure reimbursement for providing Medicaid-covered services. Refer to **Section 1.5** of this provider handbook for the HC guidelines.

Nursing facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) require prior authorization from Regional Medicaid Services (RMS) that obtains the referral from the primary care provider (PCP). No referral number is required on the billing form.

3.1.4 Covered Services

Legend drugs, physician services, and certain other costs are paid directly by DHW and separately from other long term care payments. Otherwise, the per diem rate includes all medically necessary long term care services including nursing services, room and board services, therapies, over-the-counter medications, social services, activities, and such other services required as a condition of facility certification.

3.1.4.1 Special Rates

Special rates may be requested to pay for care given to participants who have long term care needs beyond the normal scope of facility services. The payments for such specialized care will be in addition to any payments made to the facility. To request a special rate, ask the regional nurse reviewer for an *"Idaho Nursing Facility Special Rate Request Form"* to fill out and return for approval. The Department will notify the facility if its special rate request is approved or denied.

3.1.5 Swing Bed General Policy

For those hospitals that meet the Code of Federal Regulation (CFR) requirements and are approved by Centers for Medicare and Medicaid Services (CMS) to provide swing-bed care, a separate NF provider number is needed for reimbursement from the Medicaid program.

3.1.5.1 Reimbursement

The Department will reimburse hospital swing-beds on a per diem basis for participants eligible for a nursing home level of care. Medicaid Policy establishes rates annually by March 15 of each calendar year, to be effective January 1 of the respective year. Revenue code 100 will be used to bill for swing bed patient days. Hospitals are required to apply for a Long Term Care provider number in order to bill for swing-bed days. Hospitals cannot bill for swing-bed days under their hospital provider numbers.

Reimbursement of ancillary services not included in the swing bed rate must be billed on an outpatient claim (bill type 131) and settled on a cost basis with other outpatient services. The swing bed rate includes the same services that are included in the nursing facility per diem rate outlined at IDAPA 16.03.09.160.01 of the *Rules Governing the Medical Assistance Program*.

Prescription drugs must be billed on the outpatient pharmacy claim form.

3.2 Long Term Care Service Policy

3.2.1 Overview

Long term care services include nursing services, room and board services, therapies, over-the-counter medications, social services, activities, and such other services required as a condition of facility certification.

Note: Long Term Care services are covered for **Enhanced Plan** participants.

3.2.2 Leave of Absence

A leave of absence (LOA) occurs when a participant goes on a temporary leave of absence from the facility, such as to the hospital or home.

A day may not be billed when a participant is on a non-covered leave of absence to home, in the hospital, or is not otherwise incurring a billable Medicaid day.

When a long term care patient residing in a NF (not in an ICF/MR) goes on LOA to home, the facility may be eligible for a reserve bed payment if the facility charges private paying patients for reserve bed days. Therapeutic home visits for other than ICF/MR residents of up to three (3) days per visit and not to exceed a total of fifteen (15) days per calendar year so long as the days are part of a treatment plan ordered by the attending physician. Eligibility for reserve bed payment is determined by DHW for non-ICF/MR participants.

If the LOA is for longer than three days, written authorization must be obtained in advance from the nurse reviewer in the RMS and a copy attached to the UB-92 claim form. If a participant is discharged after 3:00 p.m. the provider may submit charges for that day. Payment for reserve bed days is the lesser of 75 percent of the NF rate or the customary charge.

Participants of ICFs/MR are allowed up to 36 LOA days to home per calendar year so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the RMS must be obtained for any home visits exceeding fourteen (14) consecutive days. Payment for reserve bed days is 100 percent of the facility rate for ICF/MR patients. Regulations addressing LOA payments are listed in IDAPA 16.03.09.160.04.

3.2.3 Long Term Care Revenue Codes

Use the following revenue codes in field 42 of the UB-92 or the appropriate field when billing electronically to indicate the level of care:

100	Inpatient days (NF, ICF/MR, or swing bed)
183	LOA (NF therapeutic leave to home)
184	LOA (ICF/MR therapeutic leave to home)

3.2.4 Third Party Insurance and Medicare Crossovers

3.2.4.1 Third Party Recovery

For participants with other nursing home insurance coverage, providers must bill the other insurance(s) prior to billing Idaho Medicaid. An explanation of benefits (EOB) from the other insurance is required with each Medicaid claim submission.

Note: An (EOB) from a primary insurance that does not include long term care coverage will not be required.

3.2.4.2 Medicare Crossovers

Part B Medicare claims will automatically cross over from Medicare to Medicaid when the provider takes assignment.

Long term care services that have been paid by Medicare Part B will cross over to Medicaid for payment when there is a deductible or coinsurance amount due for those services. Medicare Part A claims do not automatically cross over form Medicare. These claims must be submitted on paper with the Medicare EOB attached, or billed electronically without an attachment if the provider's software allows it.

Examples of some of these services covered by Part B Medicare are physical therapy, certain medical supplies, and liquid nutrition when it is 100 percent of the participant's nutritional intake. Always submit the total charges billed to Medicare, not just the allowed amount.

See General Billing **Section 2.4, Third Party Recovery** (TPR), for additional information.

3.2.5 Participant Liability or Resource Amount

Enter the participant resource amount in field 39 on the UB-92 or the appropriate field when billing electronically. Enter the amount most recently available. If the amount is later determined to be different, submit an adjustment. Correcting a resource amount cannot be accomplished on a subsequent claim.

Idaho Medicaid does not accept more than one patient liability record with a value code of 31. Field 39 a-d of the UB-92 should have the value code of 31 listed only once with a total of the patient liability listed. Do not break out the patient liabilities.

3.2.6 Adjustments

Send all long term care facility adjustments to EDS. Only a paid claim can be adjusted. EDS cannot adjust a denied or pended claim. See **Section 2.6** for instructions on how to complete the adjustment request paper form or electronically void and replace the claim.

FORM AVAILABLE: An adjustment request form with detailed instructions is included in the Forms Appendix of this handbook.

Mail to:

EDS
P.O. Box 23
Boise ID 83707

3.2.7 Type of Bill Codes

The type of bill is a three-digit code indicated in field 4 of the UB-92 or the appropriate field when billing electronically. The first two digits are always 21. The last digit depends on the type of claim billed:

211 – Admit through discharge

212 – Interim, first claim

213 – Interim, continuing claim

214 – Last claim

215 – Late charges only

3.2.8 Participant Status Codes

The participant status code is indicated in field 22 of the UB-92 claim form or in the appropriate field when billing electronically.

01 Discharge to home
02 Transfer to hospital
03 Transfer to long term care facility
04 Transfer to state hospital
05 Discharged to another type of institution for inpatient care or referred for outpatient services
06 Discharge/transfer to other (Indicate in field 84 of the UB-92 or appropriate field when billing electronically, the status or location of the participant and the time they left the long term care facility)
07 Left against medical advice
08 Discharged/transferred to home under care of a home IV provider
20 Death
30 Not discharged, still a participant
40 Expired at home
41 Expired in an institution
42 Expired, place unknown

3.2.9 Admission Code for Long Term Care

Code	Type	Description
3	Elective	The participant's condition permits adequate time to schedule the availability of a suitable accommodation.

3.2.10 Source of Admission Codes

Code	Name	Description
1	Physician Referral	The participant was admitted to this facility upon recommendation of his/her personal physician.
2	Clinic Referral	The participant was admitted to this facility upon recommendation of this facility's clinic physician.
3	HMO Referral	The participant was admitted to this facility upon the recommendation of a health maintenance organization physician.
4	Transfer from a Hospital	The participant was admitted to this facility as a transfer from an acute care facility where he/she was an inpatient.
5	Transfer from a Nursing Facility or Skilled Nursing Facility	The participant was admitted to this facility as a transfer from a nursing facility or skilled nursing facility where he/she was an inpatient.
6	Transfer from Another Health Care Facility	The participant was admitted to this facility as a transfer from a health care facility other than an acute care facility, a nursing facility, or skilled nursing facility. This includes transfers from ICF/MR long term care facilities.
7	Emergency Department	Not applicable to long term care facilities.
8	Court/Law Enforcement	The participant was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.

3.2.11 Admission Hour Codes/Discharge Hour Codes

00 — 12:00 (midnight) - 12:59 a.m.

01 — 01:00-01:59 a.m.

02 — 02:00-02:59 a.m.

03 — 03:00-03:59 a.m.

04 — 04:00-04:59 a.m.

05 — 05:00-05:59 a.m.

06 — 06:00-06:59 a.m.

07 — 07:00-07:59 a.m.

08 — 08:00-08:59 a.m.

09 — 09:00-09:59 a.m.

10 — 10:00-10:59 a.m.

11 — 11:00-11:59 a.m.

12 — 12:00 (noon) - 12:59 p.m.

13 — 01:00-01:59 p.m.

14 — 02:00-02:59 p.m.

15 — 03:00-03:59 p.m.

16 — 04:00-04:59 p.m.

17 — 05:00-05:59 p.m.

18 — 06:00-06:59 p.m.

19 — 07:00-07:59 p.m.

20 — 08:00-08:59 p.m.

21 — 09:00-09:59 p.m.

22 — 10:00-10:59 p.m.

23 — 11:00-11:59 p.m.

99 — Hour Unknown

3.3 Claim Form Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red UB-92 claim forms available from local form suppliers.

All claims must be received within one year of the date of service.

3.3.2 Electronic Claims

If billing electronically, consult the user manual that comes with your software. For EDS software billing questions, consult the *Idaho PES Handbook*. Providers using vendor software or a clearinghouse should contact them for support in using their services.

3.3.3 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional claims.

Surgical procedure codes
Idaho Medicaid allows **25** surgical procedure codes on an electronic HIPAA 837 Institutional claim.

Four modifiers

On an electronic HIPAA 837 Institutional claim, where revenue codes require a corresponding HCPCS or CPT code, up to 4 modifiers are allowed. **On a paper claim**, only 2 modifiers are accepted.

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the TC modifier must be submitted.

Type of bill (TOB) codes
Idaho Medicaid rejects all electronic transactions with TOB codes ending in a value of 6. Electronic HIPAA 837 claims with valid type of bill codes not covered by Idaho Medicaid are rejected before processing.

Condition codes
Idaho Medicaid allows **24** condition codes on an electronic HIPAA 837 Institutional claim.

Value, occurrence, and occurrence span codes
Idaho Medicaid allows **24** value, **24** occurrence, and **24** occurrence span codes on the electronic HIPAA 837 Institutional claim.

Diagnosis codes
Idaho Medicaid allows **27** diagnosis codes on the electronic HIPAA 837 Institutional claim.

Electronic crossovers
Idaho allows providers to submit electronic crossover claims for Institutional services.

3.3.4 Guidelines for Paper Claim Forms

3.3.4.1 How to Complete the Paper Claim Form

The following will speed claim processing:

See **Section 3.3.4.3**, for instructions on completing specific fields.

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of twenty-two line items per claim can be accepted. If the number of services performed exceeds twenty-two lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (9 x 12 recommended)

3.3.4.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.3.4.3 Completing Specific Fields on the Paper Claim Form

Refer to **Section 3.3.4.4**, Sample Claim Form, to see a sample claim with all fields numbered. EDS denies incomplete claims, so make every effort to provide valid, complete information as specified on the claim form.

The following numbered items correspond to the UB-92 claim form. Consult the Use column to determine if information in any particular field is required and refer to the Description column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Provider Name and Address and Phone Number	Required	Enter the provider name, address and phone number. The first line on the claim form must be the same as the first line of the RA. If there has been a change of name, address, or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
4	Type of Bill	Required	Enter the three-digit code from the UB-92 manual. **211** - Admit through discharge **212** - Interim, first claim **213** - Interim, continuing claim **214** - Last claim **215** - Late charges only
6	Statement Covers Period	Required	The beginning and ending service dates of the period included on the bill.
7	Covered Days	Required	Enter the total number of days billed.
8	Noncovered Days	Desired	Enter the number of noncovered days.
11	Crossover from Medicare	Required if applicable	If billing on a paper claim, when Medicaid is the third party payer and Medicare is primary, put XOVR and attach the Medicare EOMB.
12	Patient's Name	Required	Enter the participant's name exactly as it appears on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.
17	Admission Date	Required	Enter the month, day, and year the participant was admitted to the LTC facility.
18	Admission Hour	Required	Enter the two-digit hour the participant was admitted for inpatient or outpatient care in military time. See **Section 3.2.11**.
19	Admit Type	Required for inpatient only	Only code **03** is acceptable.
20	Admit Source	Required for inpatient only	Use the two-digit source of admission codes 1 through 8 in the UB-92 manual. See **Section 3.2.11**.
21	Discharge Hour	Required if applicable	Required if the participant's status (field 22) is not **30** (still a patient). Enter the hour the participant was discharged from facility care. Enter 01 or 02 instead of 1 or 2.
22	Status	Required	Use one of the codes listed in Section 3.2.8, Participant Status Codes, to indicate client status.
32-36	Occurrence Codes and Dates	Desired	Use one of the codes listed in the Idaho UB-92 Billing Manual and enter the date of occurrence.

Field	Field Name	Use	Description
39-41	Value Codes and Amounts	Required if applicable	On LTC claims, indicate participant liability for covered services. When billing monthly, enter **31** and the entire participant's liability amount for the month on the first claim billed each month. When billing for another time period, enter **31** and prorate the participant's liability accordingly. Idaho Medicaid does not accept more than one participant liability record with a value code of 31. Field 39a-d should have the value code of 31 listed only once with a total of the participant liability listed. Do not break out the participant liabilities.
42	Revenue Codes	Required	See **Section 3.2.3** for revenues codes that are accepted by Idaho Medicaid. Use revenue code 001 for a total line and enter the claim's total in field 47.
45	Service Dates	Required if applicable	Required if billing LOA days only. Enter the "from date of service" for LOA days only.
46	Units of Service	Required	Enter the total number of covered revenue/accommodation or LOA days.
47	Total Charges	Required	Enter the total charges for each level of care revenue code.
48	Noncovered Charges	Desired	Total noncovered charges for noncovered (LOA) days.
51	Provider Number	Required	Enter the nine-digit Idaho Medicaid provider number in this space.
54	Prior Payments — Payers and Participant	Required if applicable	The amount the LTC has received toward the payment of this LTC bill from another resource NOT including the participant. See fields 39-41 for participant payments.
58	Insured's Name	Required	Participant's name must appear here.
60	Cert-SSN-HIC.-ID Number	Required	Enter the seven-digit MID number exactly as it appears on the MID card in this field. If your computer system demands an 11-digit MID, zero fill the eighth through the eleventh digits. **Example:** 02345670000 All third party resources must be billed before a claim is submitted to Medicaid. If there are other payers in addition to Medicaid, enter the name of the group or plan in fields 60A or 60A and 60B. Enter Idaho Medicaid in fields 60B or 60C as secondary or tertiary. For Medicare crossover claims, be sure the Medicaid MID number is documented in addition to the Medicare SS number.
61	Group Name	Required	Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	Insurance Group Number	Required	Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	Treatment Authorization Codes	Required if applicable	If service requires prior authorization, then report the prior authorization number in this field.
67	Principal Diagnosis Code	Required	Enter the ICD-9-CM code for the principal diagnosis.
76	Admitting Diagnosis Code	Required if applicable	Required if different from principle diagnosis.
80	Principal Procedure Code and Date	Optional	Enter the ICD-9-CM code identifying the principal surgical or obstetrical procedure. Procedure date is required.

Field	Field Name	Use	Description
81	Other Procedure Codes and Dates	Required if applicable	Procedure date is required.
82	Attending Physician ID	Required	Enter the Idaho Medicaid provider number or UPIN for the attending physician. This is the physician primarily responsible for the care of the participant from the beginning of this long-term stay.
83	Other Physician ID	Required if applicable	If applicable, enter the Healthy Connections Primary Care Physician's provider number.
84	Remarks	Required if applicable	Enter information when applicable.
85	Provider Representative	Required	Signature of the provider's authorized agent or signature on record. The claim will be denied if it is not signed.
86	Date	Required	Enter the date the claim is submitted.

3.3.4.4 Sample Paper Claim Form